

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



FOODBORNE DISEASE: CLOSTRIDIUM PERFRINGENS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 11

ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /	SSN
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**NC EDSS
LAB RESULTS**

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	



**NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE**

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): ____/____/____

CHECK ALL THAT APPLY:

Fever ☐ Y ☐ N ☐ U

☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown

Highest measured temperature _____

Unit:
☐ Fahrenheit ☐ Centigrade

Fever onset date (mm/dd/yyyy): ____/____/____

Fatigue or malaise or weakness ☐ Y ☐ N ☐ U

Dehydration ☐ Y ☐ N ☐ U

Signs of dehydration (choose all that apply):

☐ Decreased skin turgor
☐ Dry mucous membranes
☐ Non-palpable pulse
☐ Sunken eyes
☐ Decreased urine output

Prostration ☐ Y ☐ N ☐ U

Headache ☐ Y ☐ N ☐ U

Muscle aches/pains (myalgias) ☐ Y ☐ N ☐ U

Hypotension ☐ Y ☐ N ☐ U

Lowest recorded blood pressure _____

Nausea ☐ Y ☐ N ☐ U

Vomiting ☐ Y ☐ N ☐ U

Abdominal pain or cramps ☐ Y ☐ N ☐ U

Diarrhea ☐ Y ☐ N ☐ U

Describe (select all that apply)

☐ Bloody
☐ Non-bloody
☐ Watery
☐ Other

Maximum number of stools in a 24-hour period: _____

REASON FOR TESTING

Why was the patient tested for this condition?

- ☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household contact to a person reported with this disease
☐ Other, specify: _____
☐ Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) ____-____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy): ____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? ☐ Y ☐ N

If yes, specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): ____/____/____

TRAVEL/IMMIGRATION

The patient is:

- ☐ Resident of North Carolina
☐ Resident of another state or US territory
☐ None of the above

Did patient have a travel history during the 24 hours prior to onset of symptoms? ☐ Y ☐ N ☐ U

Travel dates: From: ____ until ____

To city: _____

To country: _____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

Name: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Is patient a student? ☐ Y ☐ N ☐ U

Type of school: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Give details: _____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

BEHAVIORAL RISK & CONGREGATE LIVING

During the 24 hours prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? ☐ Y ☐ N ☐ U

Name of facility: _____

Dates of contact: _____

During the 24 hours prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility / Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

FOOD RISK AND EXPOSURE

During the 24 hours prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? ☐ Y ☐ N ☐ U

Specify meat/poultry: _____

Specify place of exposure: _____

During the 24 hours prior to onset of symptoms, was the patient:

Employed as food worker? ☐ Y ☐ N ☐ U

Where employed? _____

Specify job duties: _____

What dates did the patient work? _____

Employed as food worker while symptomatic? ☐ Y ☐ N ☐ U

Where did the patient work? _____

What dates did the patient work? _____

What day did the patient return to food service work? Date: _____

Where did patient return to work? _____

Non-occupational food worker? (e.g. potlucks, receptions) during contagious period? ☐ Y ☐ N ☐ U

Where employed? _____

Specify dates worked during contagious period: _____

Health care worker or child care worker handling food or medication in the contagious period? ☐ Y ☐ N ☐ U

Where employed? _____

Specify dates worked during contagious period: _____

Comments: _____

FOOD RISK AND EXPOSURE (continued)

During the 24 hours prior to onset of symptoms, did the patient:

Handle raw meat other than poultry? ☐ Y ☐ N ☐ U

Specify type of meat:

☐ Beef (hamburger/steak, etc)

☐ Pork (ham, bacon, pork chops, sausage, etc)

☐ Lamb/mutton

☐ Wild game, specify: _____

☐ Other, specify: _____

☐ Unknown

Handle raw poultry? ☐ Y ☐ N ☐ U

Specify type of poultry:

☐ Chicken

☐ Turkey

☐ Other, specify: _____

☐ Unknown

Eat ground beef/hamburger? ☐ Y ☐ N ☐ U

Eat other beef/beef products? ☐ Y ☐ N ☐ U

☐ Roast

☐ Steak

☐ Other, specify: _____

Eat any poultry/poultry product? ☐ Y ☐ N ☐ U

Eat pork/pork products? ☐ Y ☐ N ☐ U

Specify type of pork/pork product:

☐ Sausage

☐ Smoked ☐ Unsmoked

☐ Chops

☐ Roast

☐ Ham

☐ Smoked ☐ Cured ☐ Canned

☐ Other, specify: _____

☐ Bacon

☐ BBQ

☐ Other, specify: _____

Eat wild game meat (deer, bear, wild boar)? ☐ Y ☐ N ☐ U

Specify type of wild game meat:

☐ Deer/venison

☐ Bear

☐ Wild boar/javelina/feral hog

☐ Other, specify: _____

Eat other meat / meat products (i.e. ostrich, emu, horse)? ☐ Y ☐ N ☐ U

Specify other meat/meat product:

☐ Ostrich

☐ Emu

☐ Horse

☐ Other, specify: _____

Eat deli-sliced (not pre-packaged) meat? ☐ Y ☐ N ☐ U

Specify type of meat:

☐ Bologna

☐ Turkey

☐ Ham

☐ Roast beef

☐ Chicken

☐ Other, specify: _____

Eat meat stews or meat pies? ☐ Y ☐ N ☐ U

Specify: _____

Eat gravy (i.e. beef, chicken, turkey)? ☐ Y ☐ N ☐ U

Specify: _____

Eat at a group meal? ☐ Y ☐ N ☐ U

Specify:

☐ Place of Worship

☐ School:

☐ Social function

☐ Other, Specify: _____

Eat food from a restaurant? ☐ Y ☐ N ☐ U

Name: _____

Location: _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify: _____

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed? _____

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed: _____

Notes on medical record verification: _____

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County _____

☐ Outside NC, but within US

City _____

State _____

County _____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes regarding setting of exposure: _____

Foodborne disease: *Clostridium perfringens*

2007 Case Definition (North Carolina)

Clinical description

An illness characterized by acute onset of some or all of the following symptoms: colic, nausea, and diarrhea; vomiting and fever are usually absent. Symptom onset occurs within 24 hours following ingestion of food contaminated with toxins produced by *Clostridium perfringens*.

Laboratory criteria for diagnosis

- Isolation of *Clostridium perfringens* from clinical stool specimen or
- Demonstration of enterotoxins produced by *Clostridium perfringens* in a stool sample
- Isolation of *Clostridium perfringens* from a leftover food sample
- Positive *Clostridium perfringens* toxin assay in a leftover food sample

Case classification

Confirmed:

- a clinically compatible case with a positive culture for *Clostridium perfringens* in a stool specimen,
or
- a clinically compatible case with demonstration of enterotoxins produced by *Clostridium perfringens* in a stool specimen

Probable:

- a clinically compatible case epidemiologically linked to a confirmed case, **or**
- a clinically compatible case who provides a leftover food sample that
 - cultures positive for *Clostridium perfringens*,
or
 - tests positive for *Clostridium perfringens* toxin